Jewett (Chas)

THREE RECENT SYMPHYSEOTOMIES.*

By Charles Jewett, M. D.

N. O., Irish, aged twenty-eight years, II-para, admitted to the Long Island College Hospital January, 1896. In her first confinement she had been delivered in my service after an easy labor, the child weighing six pounds. The pelvic measurements were as follows: Interspinal, 23.5 centimetres (nine inches and a quarter); intercristal, 26.1 centimetres (ten inches and a quarter); external conjugate, 17.3 centimetres (seven inches); diagonal conjugate, 10.2 centimetres (four inches). The woman fell in labor at term, April 11, 1896. The presentation was primarily a right scapulo-anterior, but was subsequently reduced to vertex by manual interference. At the close of the first stage axis-traction forceps was applied tentatively, but the head could not be brought into the brim. The pubic joint was divided as follows: An incision beginning well above the level of the pubic bones was carried down over the joint to the clitoris, exposing the prepubic fibrous structures. The abdominal wall was opened to the extent of an inch or more above the symphysis in the median line. A V-shaped incision parallel with the crura of the clitoris, and immediately above them, was then made down to the bone dividing the suspensory ligament. With a strong, sharp double hook, caught in the angle of the V, the clitoris was drawn down below the summit of the subpubic arch. A few touches of the scalpel exposed the lower end of the symphysis. An improvised sharply curved director was passed behind the symphysis close to the interpubic disk, pushing back the retropubic vessels. The joint was divided with a blunt-pointed bistoury passed on the director, and the bones separated two inches and a half.

There was some hæmorrhage from the prepubic incision, but

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* Reprinted from the Transactions of the New York Obstetrical Society, in the American Gynæcological and Obstetrical Journal for November, 1896.

none from the veins behind and below the joint, and no other complication. The delivery was effected with the axis-traction forceps. The wound was sutured with silkworm gut, the sutures passing through the fibrous structures in front of the joint. The pelvis was immobilized by means of the usual adhesive straps and muslin binder. In addition to this, a firm hair pillow was placed under each lateral half of the pelvis. On these lateral supports the pelvis rested during the entire period of convalescence. The temperature did not exceed the usual normal puerperal limit. Slight suppuration occurred at one point to the depth of the skin, but, with that exception, the wound united promptly throughout. The woman left her bed at the end of four weeks with good union of the joint.

The child, a male, weighed nine pounds and three quarters. Its biparietal diameter was four inches, the suboccipito-bregmatic four inches and a quarter, and the corresponding circumference fourteen inches. The anterior fontanelle was small, and the cranial bones firmly ossified. At the last report received from the mother the child was living and well.

Mrs. H., an Englishwoman, aged twenty-five years; II-para. First labor terminated by craniotomy. Pelvis ample except at outlet. Interspinal diameter, 25.4 centimetres (ten inches); intercristal, 26.7 centimetres (ten inches and a half); external conjugate, 20 centimetres (seven inches and seven eighths); diagonal conjugate, 12.7 centimetres (five inches); the bis-ischial diameter was 8.2 centimetres (three inches and a quarter). The child presented by the breech. June 17th, several days before the expected date of confinement, labor was induced by the use of intra-uterine bougies and a cervical tamponade of gauze. On the following day dilatation, which was well under way, was completed manually. The symphysis was then divided by the same method as in the preceding case, and the bones separated to the extent of two inches and three quarters.

Up to this time there was no hæmorrhage from the retropubic veins. The child was readily extracted by the feet. The delivery was necessarily rapid. The assistants who were intrusted with the duty of supporting the lateral halves of the pelvis were inexperienced, and the bones were permitted to spring widely apart as the head came down. The anterior soft parts were completely torn through, the laceration running along immediately to the right of the urethra and extending into the base of the bladder. There was

considerable bleeding from the torn structures. The bladder wall was closed with a running suture of fine catgut, and the vaginal wall in a similar manner. The incision was united with silkworm-gut sutures, which included the prepubic fibrous structures. A soft catheter was left in the bladder for three days. The patient suffered considerable shock, but made a perfect recovery. The incision healed without suppuration. The sutures were removed on the seventeenth day. The woman was out of bed at the end of a month, and was soon after able to walk without pain or inconvenience. Restoration of the joint was apparently complete. A urinary fistula persisted for nearly four weeks, but had wholly closed at the time the patient left her bed.

The child is living and in robust health. Five days after birth its weight was seven pounds and three quarters. The birth weight was not taken, but must have exceeded eight pounds. The biparietal diameter was four inches, the suboccipito-bregmatic circumference thirteen inches, the occipito-frontal fourteen inches.

M. K., an Austrian woman, aged thirty-one years, V-para, admitted to the Long Island College Hospital July 27, 1896. Previous labors difficult; all the children lost. General health good. Presentation vertex, left occipito-anterior. Perinæum torn to mucous membrane of rectum. Rectocele and cystocele. Interspinal diameter, 25.4 centimetres (ten inches); intercristal, 28 centimetres (eleven inches); external conjugate, 18 centimetres (seven inches and a quarter); diagonal conjugate, 10.8 centimetres (four inches and a quarter). Labor began at term, September 3, 1896. Twenty-nine hours later, the pains for several hours having been of the most vigorous description, the head was found arrested at the brim in transverse position, with the occiput to the left. Fœtal heart fairly strong. Symphyseotomy was decided on, and was performed as in the foregoing cases. The symphysis was to the right of the median line. Having no suitable director at hand, the joint was divided with the blunt-pointed bistoury, guided by the finger in the retropubic space. Free bleeding, controlled by gauze packing. Separation of pubic bones about two inches. Child easily extracted with forceps in a condition of partial asphyxia.

The wound, which was closed with a single row of silkworm-gut sutures, healed *per primam.* Temperature scarcely above the normal throughout. The coaptation of the bones was maintained as in the preceding cases. The use of the catheter was at no time

required. The sutures were removed September 15th, and the patient was out of bed October 1st. Satisfactory union of the joint was obtained, and the pelvic organs were in as good condition as before operation. In this, as in most cases that I have examined within a few weeks after symphyseotomy, there was a barely perceptible motion of the pubic bones on each other when the patient stood and rocked the body, putting her weight first on one foot, then on the other. The woman, however, was wholly unconscious of any defect in the joint, and she walked without difficulty on the third day after getting out of bed. Some relaxation of the symphysis may be demonstrated after labor in many women delivered without symphyseotomy. The child weighed seven pounds and three quarters, and measured twenty inches in length. Directly after birth the head measurements were as follows: Biparietal, $3\frac{1}{2}$; bitemporal, $3\frac{1}{2}$; suboccipito-bregmatic, $4\frac{1}{4}$; occipito-mental, $5\frac{1}{4}$. A few days after birth a superficial skin slough over the left parietal bone marked the point where the head had rested against the promontory. At the date of this report the child weighed nine pounds and three quarters, and was thriving.

Discussion.

Dr. Bache Emmet inquired whether, after having performed symphyseotomy, it would not be desirable to retard the delivery so as to bring the parts to the same dilatation as would occur naturally, and thus spare the injury which took place by the extraction of the head before the parts were made to yield at all. He would like to know whether any injury would follow by making the extraction slowly, instead of drawing through with possible haste.

Dr. Jewett replied that the general opinion was in favor of delivering promptly. He thought it was better to deliver by the forceps, as a rule; the danger of injury to the soft parts was less by this means than by version. With reference to the dilatation of the parts, that should be provided beforehand. The cervix should be fully dilated, and so should the vagina. In case of anticipated difficulty at the introitus, episiotomy cuts might be made on either side to take the strain off the anterior soft parts. Injury of the kind reported, he thought, might be prevented by some apparatus to hold the lateral halves of the pelvis more securely during delivery than was possible manually. The French had an instrument for the purpose. Many

such accidents had no doubt occurred; they were spoken of by all writers as very liable to happen, and he was surprised that it could so easily take place as in his case. The tear might come from the strain on the perineal fascia by the separation of the bones, and not necessarily by the pressure of the child. A breech extraction increased the risk of laceration, since the delivery must be rapid and considerable manipulation was required within the passages.

Dr. DUDLEY, alluding to Dr. Jewett's cases of symphyseotomy, said that he had discussed the subject with Dr. Morisani, at the International Gynæcological Congress, who was very decided about repeating operations. The speaker had narrated the case reported by him in the spring, where he had such difficulty in delivering the child after having made symphyseotomy, and asked Dr. Morisani whether he would do a second symphyseotomy in such cases. The reply was that he would, by making an open incision, wiring the bones together after delivery. As to whether he would repeat symphyseotomy in preference to Cæsarean section or Porro's operation, or delivering a dead fœtus, Morisani said that he would.